# Reporting Adverse Reactions: MedWatch Form FDA 3500A

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**FDA** 

Centers for Biologics Evaluation and Research (CBER)
Office of Biostatistics and Epidemiology
Therapeutics and Blood Safety Branch

### MedWatch and HCT/P Safety

 With MedWatch, FDA can detect trends across the country that may not be identified at an individual site.

 Goal of HCT/P surveillance is to prevent additional adverse reactions.

### It is a reportable HCT/P adverse reaction, now what do I do?

You have 15 days from receipt of information

Use Form FDA 3500A (MedWatch)

Obtain from CBER or electronically from: <a href="https://www.fda.gov/medwatch">www.fda.gov/medwatch</a> or <a href="https://www.hhs.gov/forms">www.hhs.gov/forms</a>

#### MedWatch forms: http://www.fda.gov/medwatch/



#### U.S. Food and Drug Administration



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Welcome to MedWatch, your Internet gateway for timely safety. information on the drugs and other medical products regulated by the U.S. Food and Drug Administration.

#### What's New

Cordarone (amiodarone HCI) - New Medication Guide issued, to be provided with each prescription dispensed to patients. (Posted 01/10/2005)

Avastin (bevacizumab) - WARNINGS, PRECAUTIONS, ADVERSE EVENTS, and DOSAGE AND ADMINISTRATION sections of labeling updated to describe arterial thromboembolic events when Avastin is used in combination with intravenous 5-fluorouracil-based chemotherapy. (Posted 01/06/2005)

American Health & Herbs Ministry Eye Rinse Products - Voluntary recall

#### Safety Information



#### **Medical Product** Reporting



# Reporting Adverse Reactions with MedWatch:

### Form FDA 3500A

(3500 for Voluntary)
Page 1

	Information and Reporting Progra	2		Page of _	20 10	1		1920	100
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### MedWatch Form FDA 3500A

Page 1

**Section A:** Patient Information

Section B: Adverse Event, Product Problem or Error

A. PATIENT IN	FORMATION			
. Patient Identifier	of Event:	2/5	3. Sex	4. Weight
in confidence	Or Date of Birth:	70	☐ Female	or logs
. ADVERSE E	VENT OR PRODU	ICT PROBLE	Mari	
Adverse Even	t and/or Pr	oduct Problem (e.	g , defects/meth	unctions)
Outcomes Attribut (Check all that app	ted to Adverse Event (y)	Disability	7. 04:25:31:32	
Death:	our.	Congenital		
Life-threatening	(moldayiyr) a		stervention to P Impairment/De	
(00)	- initial or prolonged	Other.		
Date of Event (mo	stayiyear)	4. Date of This	Report (molde	y/year)
Describe Eventor	Paris Salara			
Describe Event or	Problem			
Relevant Tests/La	boratory Data, Includi	ng Dates		
	story, Including Preex	ieting Madical Co	nditions (o.a.	allaraias
Other Relevant His				

### MedWatch Form FDA 3500A Page 1

For HCTP's:

Use Section C
for Suspect
Medication(s)
not
Section D for
Suspect Device

8. Event Reappeared After Reintroduction?  #2 #2 #1   Yes   No   Doesn't Apply  #3   Yes   No   Doesn't Apply  #4   Yes   No   Doesn't Apply  #5   Yes   No   Doesn't Apply  #6   Concomitant Medical Products and Therapy Dates (Exclude treatment of event)  #6   D. SUSPECT   CollCAL DEVICE  #7   Brand Nave  #8   Lot #   Lot #   S. Operator of Device  #8   Model #   Lot #   S. Operator of Device   Health Professional   Lay User/Patient  #8   Shial #   Other #   Cother   Other   Other    #8   Implanted, Give Date (morbinylyr)   7. If Explanted, Give Date (morbinylyr)  #8   Shial #   Device Device that was Reprocessed and Reused of # Patient?	C. SUSPECT	LICATION(S)		
2. Dose, Frequency & Route Used  3. Therapy Dates (if unknown, give duration)  41  42  42  43  5. Event Absted After Use Stopped or Dose Reduced?  41	<ol> <li>More (Give labeled):</li> </ol>	strength & miniebaler,	if known)	
2. Dose, Frequency & Route Used  3. Therapy Dates (if unknown, give duration) frontito (or bast estimate)  3. Therapy Dates (if unknown, give duration) frontito (or bast estimate)  3. Diagnosis for Use (indication)  3. Event Absted After Use Stopped or Dose Reduced?  3. Lot # (if known)  3. Event Reappeared After Reinfroduction?  3. Lot # (if known)  3. Event Reappeared After Reinfroduction?  3. NoDC# (For product problems only)  4. Event Reappeared After Reinfroduction?  3. Nonefacturer Name, City and State  D. SUSPECT COICAL DEVICE  1. Brand Name  2. Typyoff Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  3. Variefacturer Name, City and State  D. Suspect Colcal Device  D.	<b>#1</b>			
Second Diagnosis for Use (Indication)   Seco	#2			
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Stopped or Dose Reduced?  #1	250	n Kradina)	#2	Consul Abatasi After Use
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#2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #2 #	6. Let# (l'inown)	7. Exp. Date (if:	known)	— Apply
3. NDC# (For product problems only)  2. Type of Device 3. Manufacturer Name, City and State  D. SUSPECT **COICAL DEVICE  1. Brand Name  2. Type of Device 3. Manufacturer Name, City and State  Description Date (molday/yr)  State  Catalog # Expiration Date (molday/yr)  State  Cher # Other # Other  3. If Implified, Give Date (molday/yr)  3. Is this a Single-bat Device that was Reprocessed and Reused on a Patient?  Vec No  E. INITIAL REPORTER  1. Name and Address  Phone #  2. Health Professional? 3. Occupation  4. Initial Reporter Also Sent Report to FDA	#1	<b>#1</b>		
Suspect   Concomitant Medical Products and Therapy Dates (Exclude treatment of event)	#2	#2		
D. SUSPECT **CDICAL DEVICE  Brand Nave  Typy of Device  Typy o	<ol><li>NDC# (For product pr</li></ol>	roblems only)		D D D Donner
D. SUSPECT Parolical Dievice  8. Manufacturer Name, City and State  1. Model # Lot # 5. Operator of Device  1. Catalog # Expiration Date (moldsylyr) Health Professional  1. Social # Other # Cother:  1. If Implicated, Give Date (moldsylyr)  2. If Explanted, Give Date (moldsylyr)  3. Is this a Single-on-Device that was Reprocessed and Reused of a Patient?  1. Name and Address Phone #  2. Health Professional?  3. Occupation  4. Initial Reporter Also Sent Report to FDA				
Model # Lot # 5. Operator of Device   Health Professional   Lay User/Patie/t:   Other #   Other #   Other   Other:   Other:   Other:   This is Single-one Device that was Reprocessed and Reused of a Patient?   E. INITIAL REPORTER   Name and Address   Phone #   Phone Ph	Control of the Contro			
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Catalog # Expiration Date (moldaylyr)   Health Professional   Lay User/Patie/t   Other:  Shial # Other # Other:  3. If Implified, Give Date (moldaylyr)   7. If Explanted, Give Date (moldaylyr)   3. Is this a Single-bas Device that was Reprocessed and Reused of a Patient?    Vos.	3. Manufacturer Name,	City and State		
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3. If Implified, G/ & Date (molbaylyr)  7. If Explanted, Give Date (molbaylyr)  8. Is this a Single-bar Device that was Reprocessed and Reused of a PaSent?  1. Name and Address  Phone #  2. Health Professional?  3. Occupation  4. Initial Reporter Also Sent Report to FDA	Catalog #	Expiration	on Date (	(molday/yr) Lay User/Patie t
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2. Health Professional? 3. Occupation 4. Initial Reporter Also Sent Report to FDA	THE RESERVE OF THE PARTY OF THE	RTER	**********	
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Report to FDA				
Report to FDA				
Report to FDA				
Report to FDA	2. Health Professional	? 3. Occupation		4. Initial Reporter Also Sent
				Report to FDA

### Filling out Section C. for an HCT/P

- C1. Name, manufacturer
- C3. Dates of Use:
  - #1 Date of implant
  - #2 Date of explant, if applies
- C4. Diagnosis or Reason for use
- C6. Lot #
- C7. Expiration # C10. Concomitant Medical Products

#1 Tibialis Ten	don Joi	ntsave C	ompany .
#2			
2. Dose, Frequency & R	oute Used		rapy Dates (If unknown, give duration /to (or best estimate)
#1		2.1 60000	1/9/04
#2		#2 1	1/30/04
4. Diagnosis for Use (In #1 ACL repair #2	dication)		5. Event Abated After Use Stopped or Dose Reduced? #1 Yes No Doesn Apply
6. Lot # (if known)	7. Exp. Date	(if known)	#2 Yes No Doesn
#1 AZ2004-1264	2127 Dankonkrongs	8/05	8. Event Reappeared After
#2	#2		Reintroduction? #1 Yes No Doesn
9. NDC# (For product pro	blems only) -		#2 Yes No Doesn
		Th	es (Exclude treatment of event)

(C2, C5, C8, C9 are not relevant for HCT/P's)

## Proposed MedWatch 3500A

Changes in this section:

Section D.
Suspect PRODUCT(S)

D9. NDC# or Unique ID

D. SUSPECT	PRODUCT(S)			FDA Use Onl
N 1845 72 N ES	n, manufacturer (from	product label)		
#1				
#2				
2. Dose or Am	ount	Frequency	Rout	te
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#2	-			
			100 mg	
<ol> <li>Dates of Use(I best estimate)</li> </ol>	funknown, give duratio	on) from/to (or	<ol><li>Event Abated Aft Stopped or Dose</li></ol>	
#1			#1 Yes No	□ Dooen
#2	easen for Use Andies	etion)		Doesn Apply
#2	eason for Use (Indica	ition)	#1 Yes No	Doesn Apply Doesn Apply Apply
#2 4. Diagnosis or R	eason for Use (Indica	ition)	#1 Yes No	Doesn Apply Doesn Apply Apply Apply
#2 4. Diagnosis or R #1 #2	eason for Use (Indica 7. Expiration		#1 Yes No	Doesn Apply  Doesn Apply  Apply  Apply  Doesn Apply
#2 4. Diagnosis or R			#1 Yes No #2 Yes No 8. Event Reappeare Reintroduction? #1 Yes No	Doesn Apply  Doesn Apply  Apply  Doesn Apply  Doesn Apply  Doesn Apply  Doesn Apply

### Section E.

Initial Reporter (who reported to you)

E. INITIAL REPORTER				
1. Name and Address	Phone #			
	÷.			
	L	L 1-22-10-1-10-1-10-10-10-10-10-10-10-10-10-10		
2. Health Professional?	3. Occupation	4. Initial Reporter Also Sent Report to FDA		
YesNo		Yes No Unk.		

### MedWatch Form FDA 3500A

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Section F: For Use by User Facility/Importer (Devices Only)

Section G: All Manufacturers

**Section H:** Device Manufacturers

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### MedWatch Form Form FDA 3500A

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**Section G\*** 

(Sections F and H are for device manufacturers)

<ol> <li>Contact Office - Name/Address for Devices)</li> </ol>	(and Manufacturing Site	2. Phone Number
		3. Report Source (Check all that apply)  Foreign Study Literature Consumer Health Professional
Date Received by Manufacturer (mo/day/yr)	5. (A)NDA # IND #_	User Facility Company Representative Distributor
6. If IND, Give Protocol #  7. Type of Report (Check all that apply)	PLA #  Pre-1938	Other:
5-day 15-day 10-day Periodic Initial Follow-up #	8. Adverse Event Term(	(s)
9. Manufacturer Report Number	<u>-</u>	

\* Will be Section I in the Revised 3500A

#### Filling out MedWatch on-line (fillable pdf)

http://www.fda.gov/medwatch/getforms.htm

Saving and/or Retrieving your data can only be done with the full version of the		
Ave Data Print Next Page Retrieve Data Reset  U.S. Department of Health and Human Services	Form Appr	oved: OMB No. 0910-0291, Expires: 03/31/05 See OMB statement on reverse.
For use by t	user-facilities, ors and manufacturers FORY reporting  Mfr Report # UF/Importer Report #	
The FDA Safety Information and Adverse Event Reporting Program	of	FDA Use Only
A. PATIENT INFORMATION  1. Patient Identifier  2. Age at Time of Event: or Date of Birth:  Section A - Help  3. Sex 4. Weight Female or Male	C. SUSPECT MEDICATION(S)  1. Name (Give labeled strength & mft/labeler, if known #1 #2	ction C - Help
B. ADVERSE EVENT OR PRODUCT PROBLEM Section B - Help  1. Adverse Event and/or Product Problem (e.g., defects/malfunctions)  2. Outcomes Attributed to Adverse Event		nerapy Dates (If unknown, give duration) om/to (or best estimate)
(Check all that apply)  Death:  (moldaylyr)  Congenital Anomaly  Required Intervention to Prevent Permanent Impairment/Damage  Hospitalization - initial or prolonged  Other:	4. Diagnosis for Use (Indication)  #1  #2  8. Lot # (if known)  7. Exp. Date (if known)	5. Event Abated After Use Stopped or Dose Reduced? #1 Yes No Doesn't Apply  #2 Yes No Doesn't Apply
Date of Event (mo/day/year)     4. Date of This Report (mo/day/year)      Describe Event or Problem	#1 #1 #2	8. Event Reappeared After Reintroduction? #1 Yes No Doesn't Apply
3. Describe Event of Froblem	9. NDC# (Far product problems only)	#2 Yes No Doesn't
SE BLACK INK	D. SUSPECT MEDICAL DEVICE  1. Brand Name  2. Type of Device	Section D - Help

### Where do I submit the MedWatch form?

Send 2 copies of each MedWatch report to:

Center for Biologics Evaluation and Research

HFM-210

1401 Rockville Pike, Suite 200N

Rockville, MD 20852

# Common MedWatch Problems

### **Device Section** filled out

	ection A - Help	C. SUSPECT MEDICAT		Help
1. Padent Identifier 2. Age at Time of Event 35	Ye V R Fernsie 238 bt	<ol> <li>Hame (Give labeled strength</li> </ol>	a melabetic districts	
Oute	_ or	#2		7
in confidence of Birth:	Halebgs	2. Date, Frequency & Route U	ed 3. Therapy Dat	es (Yankstwe, give duration)
B. ADVIERSE EVENT OR PRODU	21 CE-072 (2012) VIX. N.C. N.C. N.C. N.C. N.C. N.C. N.C. N.	*1	framés jor be	er erectae)
Adverse Event and/or Pro     Outcomes Attributed to Adverse Event	duct Problem (e.g., defectnéssité notions)	#2	92	T.
(Check all that apply)	Congenital Anomaly	4. Diagnosis for Use (Indicator		ent Abased After Use
Death: (moldayiyr)	Required Intervention to Prevent	# ACL repair		yes No DoseReduced? Yes No Dosen't
Life-threatening	Permanent Impairment/Damage	#2	e l	Count
Hospitalization - initial or prolonged	Coher	6. Lot # (Finance) 7.1	and the same of	-54-9
3. Date of Event /moltps/war/ 11/30/2004	4. Date of This Report /moltan/mari 12/02/2004	92 92		ent Reappeared After introduction? Yes: No 000001
5. Describe Event or Problem	)	9. HDC# (For product problems	onb)	Yes No Doesn't
tendom om 11/09/2004, she de 11/22/04 and was started on worzened and she required as	aveloged septic arthritis on antibiotics. Symptoms plantation on 11/30/04.	10. Concomitant Medical Prod  D. Salver of Event Medical Prod  Drand Marse Joint Salve  2. Type of Davice Tibialis  3. Marse Company, Springfield, IL  4. Medel #  Catalog #  Serial #  5. Einplanted, Give Date (ma)	Lot # AD2004-1264 Superside One (mother) Other #	S. Operator of Device
6. Relevant Tests/Laboratory Data, Includin	g Dates	11/09/2004	zagryt) / If suspensives,	11/20/04
Mound oulture 11/27/64. St.		B. In this a Single-use Device to Yes No. 9. We No. 9. Erves to item No. 8. Enter No. 9. Event No. 9. Enter No. 9. Event No. 9. Enter No. 9. Event No. 9. Event No. 9. Event No. 9. No. 9. 11. Concomitant Medical Prod	ans and Address of Reproce ation? (Do not rend to FDA) Returned to Manufacturer on:	(moldaylyr)
<ol> <li>Other Relevant History, including Precoi- case, pregnancy, smoking and stochol use.</li> </ol>	rling Medical Conditions (e.g., allergies, hepatichetal dyntamics, etc.)	Cephalexin 500 mg p  E. INHMAL DEPOSITE: 1. Hame and Address  John Doe 122 Main St Dallas, TX 12245	o b44 11/22-11/30/0	4
an admission	a report does not constitute that medical personnel, user a distributor in profesturer or	2. Health Professional? 13. Oc	cupation	A. Initial Reporter Also Sent

# Common MedWatch Problems

No suspect product name

A. PATIENT INECEMATION  1. Patient Identifier   2: Age at Time	Section A - Help  3. Sex 4. Weight		MEATHON(S) Se		e'p
APD 2. Age at time of Event: 35	Ve -1	1. Halle (University Research)	renger a residuent cristo	-	
Or Date	or or	**	$\overline{}$		
in confidence of Birth:	Main kgs	2. Done, Frequency & R.	oute Used A. Tr	herapy Dules	Yunknown also duration)
B. ADVERSE EVENT OR PROOL	107	•	ei ei		(Yunktowo, give duration) estimate)
Advense Event and/or Pro     Outcomes Attributed to Adverse Event	oduct Problem (e.g., defectnimalismotions)	#2	#2		
(Check of that apply)	Chabley	4. Diagnosis for Use (in	deaten)		Abated After Use
Death: (moldaster)	Congenital Anomaly  Required intervention to Prevent	# ACL repair		Stopp	ed or Dose Reduced? res No Doesn't Apply
Life-threatening	Permanent Impairment/Damage	<b>e</b> 2			-94-2
Hospitalization - initial or prolonged	Other:	6. Lot # (Finance)	7. Exp. Date (Microsoft)	#2 E	res No Deen't
3. Date of Event /moitswiwari	4. Date of This Report (moltanhear)	#1	ei	0. Event	Reappeared After oduction?
11/20/2004	12/02/2004	#2	42		res No Doesn't
5. Describe Event or Problem		9. HDC# (Fer product pro	diens only)		Apply
35 yo woman underwent ACL t	raneplant with tibialis eveloped septic arthritis on antibiotics. Symptoms	_	-	62 🔲	res No Doesn't
		Reand Name     Type of Davice     Harnefacturer Hanse.     Joseph Save. Company	City and State	Section D	- Help
		Springfield, DL	**		Acet Laboration
		4. Blodel #	Lot # AZ2004-126	•	5. Operator of Device
		Catalog #	Expiration Dat 9/5/	e (moldayóri)	
		Serial #	Other#		☐ Other
6. Relevant Tests/Laboratory Data, Include	an Cartes	6. #Implanted, Give Da 11/09/			ve Date (ma/day/yr) 1/30/04
Mound culture 11/27/04. St	ADM NO COLUMN		evice that was Reprocess	ed and Reuse	ed on a Putient?
		Yes No	Inter Name and Address o	I December	
			are near 212 marts.	и опрежения	
		☐ Yes ☐ No	Englastian? (Do not rend  Returned to Manufa	clurer on	(marktaylyr)
<ol> <li>Other Reinmant History, Including Pressi race, pregnancy, moking and alcohol use.</li> </ol>	nling Medical Conditions (e.g., aflergies, Aspaticional dynamica, etc.)	YARLEMEN CONTRACTOR CONTRACTOR	eg po bid 11/23-		e beatment of event)
		E. INITIAL REPOR	Chops #	23 - 234 - 34	
		John Doe 123 Main St Dallas, TX 1234	ı		
an admission facility, imports	a report does not constitute that medical personnel, user er, distributor, manufacturer or	2. Health Professional?	Control of the Contro		Initial Reporter Also Sent Report to FOA
FORM FDA 3600A (8/03)	d or contributed to the event.	⊠ Yes ☐ No	Other Healthcare Pro	(C)	Yes No 🗵 Unk

# Common MedWatch Problems

Nonspecific product name

No manufacturer name

1. Name (Give labeled : #1 Tissue	arengar a minabele	, 11 111011117	
#2			
2. Dose, Frequency &	Route Used		apy Dates (If unknown, give dura to (or best estimate)
#1		10,00000	1/09/2004
#2		#2 11	1/20/2004
4. Diagnosis for Use (Fig. 4.) ACL repair #2	Indication)		5. Event Abated After Use Stopped or Dose Reduced #1 Yes No Do
6. Lot # (if known)	7. Exp. Date (if	known)	#2 Yes No A
#1	#1		8. Event Reappeared After Reintroduction?
#2	#2		#1 Yes No A
9. NDC# (For product p	roblems only) -		#2 Yes No A
10. Concomitant Medic	eal Products and Th	erapy Date	es (Exclude treatment of event)

### **BRAVO!**

MEDWATCH importers, distribu		user-facilities,	Mfr Report #			
		itors and manufacturer ATORY reporting	UF/Impoter 8			
The FDA Safety Information and Adverse Event Reporting Progra		of			PDA Ura Ora	
A. PATIENT INFORMATION  1. Patient Identifier   2. Age at Time	Section A - Help	C. SUSPECT MED			elp	
APD of Event: 35	Ye V Recule 136 be	t. Hame (Ghe labeled strong gr Tibialia Tend	SECTION TO SECTION	wave Company		
Cate		62				
in confidence of Birth:	Jerrerou B. Help		rate Used	3. Thurspy Dates : framés (or best	Yanksteen, give duration	
	roduct Problem (e.g., defectobalibrotions)	**		#1 11/09/20	A SECURITION OF THE PARTY OF TH	
2. Outcomes Attributed to Adverse Event	Clubby	#2		#2 11/50/2004		
(Check of that apply)	Congenital Anomaly	4. Diagnosis for Use (indicator) gr ACL regain		5. Event Abated After Use Stopped or Dose Reduced?		
(molity/je)	Required intervention to Prevent Permanent Impairment/Damage				#1 Yes No Apply	
Hospitalization - initial or prolonged	☐ Other	5. Let # (Fishmen)	7. Exp. Date (ff	Angeri) #2 🔲 1	res No Does	
3. Date of Event /moltanheari	4. Date of This Report (moltanhear)	py A22004-1264	#1 09/	0. Eveni	Reappeared After reduction?	
11/20/2004	12/03/2004	#2	#2		res No Does	
5. Describe Event or Problem	consistent with alberts.	9. HDC# (Fer product prod		e III.	res No Does	
35 yo woman underwent ACL t tendon on 11/09/2004. She : 11/23/04 and was started or worsened and she required a	10 Concention No. 5 - c	Products and Therapy Dales (En				
		Type of Davice     Manufacturer Name . C	ity and State			
				MARKET CONTRACTOR OF THE CONTRACTOR OF T		
		4. Hodel #	Lot #	☐ Health Profess		
		Catalog #	Expired	on Date (malbaylys)	(vi)   Lay Usen Patient	
		Serial #	Other #			
Reinvant Tests&aboratory Data, Includ	on Oake	5. Wimplanted, Give Date	(maldayiyr)	7. If Explanted, Gi	ve Date (matriaylyr)	
Wound culture 11/27/04. Staph surece		S. in this a Single-use De	It this a Single-use Device that was Reprocessed and Reused on a Parjant?     Yes No.			
		2. If Yes to item No. 5, Er	rior Hame and Ad	dress of Reprocesso	r	
		10. Device Available for i		of stand to FDA)  Manufacturer on:		
		11. Concomitant Medical			(moldaylyr) e beatment of event)	
<ol> <li>Other Relevant History, Including Press race, pregnancy, smoking and stochol use</li> </ol>	inting Medical Conditions (e.g., aflergier, , hepaticiteral dynfanction, etc.)					
		E. INITIAL REPOR	Sec	tion E - Help		
		5. Harne and Address	Phon		i c	
		John Doe				
		123 Main St Dallas, TX 12346				